



Oshkosh Community YMCA
3303 West 20th Avenue, Oshkosh, WI 54904

NON-PROFIT
ORGANIZATION
U.S. POSTAGE
PAID
OSHKOSH, WI
PERMIT NO. 145

Children are the
world's most
valuable resource
and its best hope
for the future.

John F. Kennedy

Check out the other exciting
programs the Y has to offer.
Call and ask for an
Activities Guide today!



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

SUPERVISED SUPER FUN DAYS OFF 2014-2015 KID'S DAY OUT



A supervised
environment
in which kids
can participate
in a variety of
recreational
and educational
activities on
days off school.

OSHKOSH COMMUNITY YMCA

KID'S DAY OUT

A FULL-DAY PROGRAM FOR KIDS K-12 YEARS, ON DAYS
"SCHOOL'S OUT."



Kid's Day Out is a full day, school age child care program offered on "school out" days in accordance with the Oshkosh Area School District student calendar. Children ages Kindergarten to 12 years of age will participate in arts and crafts, Family Prime Time, games, swimming, ice skating, sports, and occasional fieldtrips. Feel safe knowing your children are enjoying their "day out" in a fun, supervised environment. Morning and afternoon snack will be provided by the YMCA.

LOCATION 20TH AVE YMCA only • 3303 W. 20th Avenue

HOURS 6:30 AM-6:00 PM

DATES*

2014:

**October 24, November 10,21
December 26, 29, 30**

2015:

**January 2, 23
April 3, 6-10**

*Possible Snow days/Make up school days: March 13, May 22, June 11/12

*If school is cancelled due to weather there will be a make up school day (and No KDO). Refunds will be made for families who have registered/paid.

*If there are no make up days due to weather we will have KDO

AGE K-12 years

**FEE \$35/Day YMCA Member
\$40/Day Activity Member**

Kid's Day Out does not offer a sibling discount.



- Participants must be signed in AND out by an adult.
- Participants should bring a swimming suit and towel daily. (swimming is not required, but encouraged)
- Do not send personal belongings with your child. (playing cards, gameboys, cd players, cell phones, iPods, money, etc)
- Participants should come to the program dressed for the weather (we will go outside). Socks are required to use the Family Prime Time indoor climber.
- Participants must bring a sack lunch with beverage. Refrigeration and microwaves will not be available. Please keep this in mind when packing your child's lunch. (use insulated lunch bags with ice packs)

Limited spots
available.
**REGISTER
EARLY!!**

**Kid's Club
2014-2015 Kid's Day Out
Registration Form Age: K-12**

CHILD(REN) INFORMATION

Child's Name (Last, First)	Sex	Home Address (Street, City, State)	Zip Code	Telephone #	DOB
1.					
2.					

PARENT OR GUARDIAN INFORMATION

(All parents/guardians are permitted to visit during center hours and are allowed to pick up child(ren) unless prohibited or restricted by a court order. Attach court order, if any.)

Father/ Guardian	Name (Last, First)	Home Address (Street, City, State) Email	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #
Mother / Guardian	Name (Last, First)	Home Address (Street, City, State) Email	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #

PERSON(S) OTHER THAN PARENTS AUTHORIZED TO PICK-UP CHILD(REN)

Provide information requested for each person. If no one, write "NONE."

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #
Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #

EMERGENCY CONTACT

Provide information for the person to contact when parents/guardians cannot be reached.

YES NO This person is authorized to pick up the child.

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #

DATES NEEDED—PLEASE CHECK ALL DATES NEEDED

<input type="checkbox"/> 2014 October 24	<input type="checkbox"/> 2015 January 2	<input type="checkbox"/> Possible Make-Up Snow Days March 13
<input type="checkbox"/> November 10	<input type="checkbox"/> January 23	<input type="checkbox"/> May 22
<input type="checkbox"/> November 21	<input type="checkbox"/> April 3	<input type="checkbox"/> June 11
<input type="checkbox"/> December 26	<input type="checkbox"/> April 6	<input type="checkbox"/> June 12
<input type="checkbox"/> December 29	<input type="checkbox"/> April 7	
<input type="checkbox"/> December 30	<input type="checkbox"/> April 8	\$35/Day YMCA Member
	<input type="checkbox"/> April 9	\$40/Day Activity Member
	<input type="checkbox"/> April 10	Total Days of Care Needed _____
		Amount Enclosed \$ _____
		Signature _____



Health History	Child's Name
Child's physician or medical facility (name, address, phone number)	
1. Check any special medical condition that your child may have:	
<input type="checkbox"/> No specific medical condition <input type="checkbox"/> Cerebral palsy/motor disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/seizure disorder <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Special Diet <input type="checkbox"/> Emotional Disorder <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet/supplements <input type="checkbox"/> Other condition(s) requiring special care—specify. _____ <input type="checkbox"/> Food Allergies—Specify food(s). _____ <input type="checkbox"/> Non-food Allergies—Specify. _____	
2. Triggers that may cause problems—Specify.	
3. Signs or symptoms to watch for—Specify.	
4. Steps the child care provider should follow. If medications are necessary, a copy of the CFS-59, Authorization to Administer Medication, should be attached. Indicate any child care staff who have received specialized training/instructions to help treat symptoms.	
A. B. C.	
5. When to call parents regarding symptoms or failure to respond to treatment.	
6. When to consider that the condition requires emergency medical care or reassessment.	
7. Additional information that may be helpful to the child care provider.	

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Immunization History					
Type of Vaccine	First Dose Mo/day/yr	Second Dose Mo/day/yr	Third Dose Mo/day/yr	Fourth Dose Mo/day/yr	Fifth Dose Mo/day/yr
DTP/DT/Td DIPHTHERIA-TETANUS-PERTUSSIS					
POLIO					
HAEMOPHILUS INFLUENZA b (HIB)					
HEPATITIS B					
MEASLES, MUMPS, RUEBELLA (MMR)					
VARICELLA (Chicken Pox)					
<input type="checkbox"/> For religious reasons, this child should not be immunized. <input type="checkbox"/> For personal conviction reasons, this child should not be immunized.					

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Parent Consent/Authorization (Please initial each line & provide signature at bottom of page stating you have read and understand each item.)

_____ I understand that a copy of this program's policies and a summary of the Wisconsin Rules for Licensed Child Care Centers are available upon request.

_____ I authorize the YMCA to take my child on all fieldtrips, whether by bus transportation or by walking during program hours.

_____ I give or do not give permission for promotional photographs to be taken of my child. (Please check the appropriate box)

_____ I hereby give consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

_____ I have been informed of the number of pets in the center and their degree of contact with the enrolled children. **(WE DO NOT HAVE ANY PETS)**

Parent Signature _____ Date _____